PRISONER VERIFICATION FORM

To: Massachusetts Treatment Center	**From: Social Security Administration** _____
	Requestor: _____
	Telephone: _____
FAX: 508-279-8155	**FAX: _____**

Date of Initial Request: _____

Date of Follow-Up to Initial Request: _____

Name: _____	**Inmate Number: _____**
SSN: _____	**Date of Birth: _____**

Date of confinement/Date Committed: _____

Date Released: _____

1. SSA is requesting verification of the above incarceration information received from the Massachusetts Department of Correction. Does the above information match the information in the Department of Correction records?
   __ Yes
   __ If no, please briefly explain (Use REMARKS if necessary)

2. Has the above individual been released?
   __ If no:
   Current scheduled date of release _____
   __ If yes:
   Date of release: _____
   If released to another jurisdiction, please specify jurisdiction: _____

3. Which section of MGL 123 applies to this individual e.g. Section 7, Section 8, Section 15(b), etc? _____

4. Remarks_____
   _____
   _____
   _____
   Please contact us if you have any questions. Thank you for your cooperation.

Completed by: _____ Date: _____